HPSA incentive payments encourage primary care physicians and mid-level health professionals to provide primary care services to Medical Assistance recipients who live in medically underserved areas of Wisconsin. The HPSA Incentive Program is an adaptation of the Medicare HPSA program, with a special emphasis on primary care services. The enhanced payment assists HPSA areas in recruitment and retention of physicians and mid-level health professionals.

The reasons for targeting primary care services are discussed in the Primary Care Provider Incentive Payment (number 22 below.)

Effective for payments made on and after 10-16-93 for dates of service on and after July 1, 1993

16. Federally Qualified Health Care Centers (FQHCs)

Through two methodologies, the Wisconsin Medical Assistance Program (WMAP) pays 100% reasonable cost for services provided by Federally Qualified Health Centers (FQHCs) in compliance with Section 6303 of the State Medicaid Manual. In one methodology, providers that complete a cost report receive interim payments with final cost settlements based on their approved, finalized cost reports. In the second methodology, providers electing not to complete a cost report, accept a prospective encounter rate assigned by Department, which they indicate represents 100% of their reasonable costs without cost settlements.

FQHC reasonable cost payments are made on a per encounter basis by ascertaining the average cost per day, per provider, per recipient at the FQHC. An encounter is defined as a face-to-face contact for the provision of medical services between a single Wisconsin Medical Assistance Program (WMAP) certified provider (i.e. physician, dentist, or physical therapist) on a single day, at a single location, for a single diagnosis or treatment. When a recipient receives care from multiple WMAP-certified providers in a day, multiple encounters are recorded.

Effective 7-1-92

17. Reimbursement for HealthCheck (EPSDT) Other Services

Mental Health

a. In-home psychotherapy: An hourly rate based on usual and customary charges will be applied by type of provider rendering service (psychiatrist, psychologist, psychiatric social worker, etc.).
b. Mental health day treatment: A comprehensive hourly rate based on usual and customary charges will be applied.
c. Specialized psychological evaluation: An hourly rate based on usual and customary charges will be applied by type of provider rendering service (psychiatrist, psychologist, psychiatric social worker, etc.).

Dental Services

a. Oral examinations: Usual and customary charges subject to a maximum fee.
b. Pit and Fissure Sealants: Usual and customary charges subject to a maximum fee.
c. Single unit crowns: Usual and customary charges subject to a maximum fee.

Over-the-Counter Drugs

Manual pricing based on estimated acquisition cost plus 50% mark-up.

Assurances

All services have been reviewed to ensure that service limitations will not adversely affect HealthCheck recipients. Organ transplant services will continue to be available to children as well as adults. All payments for these services are consistent with efficiency, economy, and quality of care.

Effective 7-1-91

18. Prenatal Care Coordination Services, Health Education and Nutrition Counseling Extended Services to Pregnant Women

The Department will establish maximum allowable reimbursement rates for all covered prenatal care coordination, health education and nutrition counseling services. The risk assessment and case plan services will be paid at a flat fee, while all other services will be paid at an hourly rate. The maximum rates for prenatal care coordination, health education, and nutrition counseling services and the maximum amount allowed per recipient for all services are based on cost and payment information from eleven pilot projects and from other states with similar services. The hourly rates were derived from service specific cost and payment information. The flat rates were established by multiplying the average hourly rate for the specified service by the average length of time needed to complete the department-required procedures. All reimbursement rates were reviewed by a statewide advisory committee. The advisory committee included provider agency and consumer representatives who advised the Department on the service components, the reimbursement methodology and the risk assessment. Payments will be made at the lesser of usual and customary charges or maximum allowable fees to certified prenatal care coordination agencies. A maximum amount per recipient is paid for all prenatal care coordination, health education, nutrition counseling and outreach services. (Prenatal care coordination outreach services are administrative services.) This maximum amount for all services was established by multiplying the hourly rate by the typical number of hours needed to provide services. The maximum amount is sufficient to ensure adequate levels of service for very high risk recipients.

Effective 1-1-93

~~19.~~ Private Duty Nursing Reimbursement for Children

Private duty nursing services for children under age 21 are reimbursed at the provider's usual and customary charges or maximum allowable fees, whichever is less.

The maximum allowable fees were established to reflect the fragile medical condition of children receiving private duty nursing services. These conditions result in more complex care, requiring a higher level of skill by providers.

The maximum allowable fees are based primarily on the average hourly costs from sample data reported on the Medicare cost reports filed with the Medicare fiscal intermediary, United Government Services, by providers providing private duty nursing services for children. Based on this data, the fees are calculated to assure providers' reasonable costs will be met for skilled nursing direct care, which includes nurse salaries and fringe benefits, transportation, payroll taxes, and nurse supervision when it includes patient care and for at least 15% of providers' administrative costs for this care. The base rate was initially established years ago and is periodically increased by legislative action. The fees apply on a state-wide basis.

Effective 10-1-99

20. Pediatric Dental Service

When these services are provided to children under the age of 21, the maximum allowable fee reimbursement for all dental services is increased to 75% of CY 1994 statewide average of charges billed.

The intent of this rate increase is to improve Medical Assistance recipient access to routine pediatric dental services by increasing compensation for such care.

Effective 7-1-95

21. Nurse Midwife Service

Reimbursement for nurse midwife services is made at a percentage of a physician's payment for each specific procedure. Specifically, the nurse midwife maximum allowable fee is based on 90 percent of a physician's maximum allowable fee for that procedure. Nurse midwives are paid at a percentage of physician fees because they have less training, require physician supervision under state licensure, have a limited scope of practice and lower overhead costs.

Increased reimbursement is to encourage Medical Assistance Program participation by nurse midwives who provide quality basic level care at a lower-cost than physicians.

Effective 7-1-93

22. Primary Care Provider Incentive Payment

Primary care providers are reimbursed at a rate, when annualized, that is an estimated 2 percent over and above the established maximum allowable fee for all services they provide. For this enhanced payment, primary care providers are defined as physician assistants, nurse midwives, nurse practitioners and physician specialists in general and family practice, internal medicine, pediatrics, obstetrics and gynecology.

The intent of this rate increase is to improve Medical Assistance recipient access to primary care services, including pediatric and obstetric services, by increasing compensation to those providing primary care. In addition, many studies document that primary care providers furnish high quality health care at lower cost than other specialists.

The findings of the Physician Payment Review Commission indicate that over the past decades physician reimbursement for primary care services has grown at a much slower rate than reimbursement for other specialists. This increased reimbursement is an effort to begin to correct the imbalance in payment between primary care and other specialist providers.

Effective for payments made on and after 10-16-93 for dates of service on and after July 1, 1993

23. Specialized Medical Vehicle (SMV) Multiple Carry

On trips where more than one recipient is being transported at the same time, providers are paid at a lower rate for the second and subsequent recipients.

Effective 4-1-95

24. Reimbursement for Special Tuberculosis (TB) Related Services.

Reimbursement for these services is limited to those claims with a TB-related diagnosis. Reimbursement is through an hourly rate and a maximum amount per recipient depending on whether the recipient was TB-infected only or a suspected or confirmed TB case. Prior authorization is required for claims that exceed the maximum limitations to assure the medical necessity of exceeding these limits. Hourly rates and maximums are based on current averages to provide tuberculosis-related services by public health nursing staff at local health departments.

Effective 7-1-95

25. Reimbursement to Local Governments for Certain Services

Programs operated by local government units, which provide outpatient mental health and alcohol and other drug abuse treatment services, including services by a psychiatrist, medical day treatment services, AODA day treatment child/adolescent day treatment, personal care services, case management services, community support program services, prenatal care coordination services and/or home health services (or nursing services if home health services are not available) qualify to receive funding from the Department for operating deficits incurred to provide these services to Medicaid recipients. Operating deficits are defined as the difference between the program costs (based on the allowable cost and cost finding principles detailed in the Office of Management and Budget Circular A-87) and the Medicaid claims paid amount after adjusting for copayments and other insurance liability. Reimbursement is limited to deficits incurred to provide services to Medicaid recipients. This reimbursement cannot exceed:

- 100% of the program's operating deficit;
- the amount for which the local government has matching funds.

When the local government applies for this reimbursement, the Department will provide it to the extent FFP is available. In the event of a federal disallowance, the Department will recoup FFP monies paid to the programs under this provision.

Effective 1-1-96

26. Medication Management

The maximum allowable fee for medication management is based on the maximum fee for home health skilled nursing as well as the relative amount of time and the relative level of skill to provide the service. The fee is adjusted for travel time, overhead costs and indirect costs. The maximum allowable fee for medication management is the same for all providers because the service is virtually the same whoever provides it

Effective 7 1 95

27. Clozapine Management

The maximum allowable fee for Clozapine management is based on the average salaries for Clozapine management providers as well as the relative amount of time and the relative level of skill to provide the service. The maximum allowable fee is adjusted for travel time, overhead costs and indirect costs. The maximum allowable fee is the same for all providers because the service is essentially the same whoever provides it.

Effective 7-1-95